STATE OF MICHIGAN

DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS

OFFICE OF FINANCIAL AND INSURANCE REGULATION

Before the Commissioner of Financial and Insurance Regulation

In the matter of

XXXXX
Petitioner

v **File No. 120393-001**

Humana Insurance Company
Respondent

Issued and entered
this 28th day of September 2011
by R. Kevin Clinton
Commissioner

ORDER

I. PROCEDURAL BACKGROUND

On April 4, 2011, XXXXX (Petitioner) filed a request for external review with the Commissioner of Financial and Insurance Regulation under the Patient's Right to Independent Review Act, MCL 550.1901 *et seq.* The Petitioner receives health care benefits under an individual health plan issued by Humana Insurance Company.

The Commissioner notified Humana of the external review and requested the information used to make its adverse determination. The information was provided by Humana on April 5, 2011. On April 12, 2011, after a preliminary review of the information received, the Commissioner accepted the request for external review.

The issue here can be decided by applying the terms of the policy. The Commissioner reviews contractual issues pursuant to MCL 550.1911(7). This matter does not require a medical opinion from an independent review organization.

II. FACTUAL BACKGROUND

From January to March 2011, Petitioner completed 20 visits of physical therapy following knee surgery. Her physical therapist recommended additional physical therapy because her range of motion had not improved to the desired level.

Humana denied coverage for additional physical therapy. Petitioner appealed the denial through Humana's internal grievance process. Humana maintained its denial in its final adverse determination letter dated April 5, 2011.

III. ISSUE

Did Humana correctly deny coverage for additional physical therapy visits?

IV. ANALYSIS

Petitioner's Argument

In her request for external review, Petitioner wrote:

> I am requesting additional physical therapy due to the misdiagnosis back in September 2010. The 20 approved visits is not enough for me to return to the quality of life before my injury. I'm unable to walk without a limp and my lower back is affected as well. . . . All parties involved have expressed the need for additional physical therapy in order for me to regain normal function, mobility and range of motion.

Respondent's Argument

In its final adverse determination dated April 5, 2011, Humana wrote:

> We were unable to approve your appeal because your request for additional physical therapy visits beyond the 20 visit limit was denied correctly according to the provisions of the policy. The policy contains a benefit maximum limited to 20 visits per covered person per calendar year for physical medicine. Once the therapy benefit has been exhausted, additional physical therapy services are not eligible for benefits under the terms and provisions of the policy. The Limitations and Exclusions section of the policy indicates there is no coverage for services exceeding the amount of benefits available for a particular service. Therefore, your request for additional physical therapy visits beyond the benefit maximum of 20 visits per covered person per calendar year was appropriately denied.

Commissioner's Review

Humana denied coverage for the additional physical therapy services on the grounds the Petitioner had already exhausted the maximum 20 physical therapy benefits allowed according to the provisions in the policy. The policy's "Major Medical Expense Outline of Coverage" describes the physical medicine benefit as "outpatient therapy services for up to 20 visits per covered person per calendar year." This is the benefit Humana provided.

The Commissioner finds that Humana's denial of coverage for the additional physical therapy treatments is consistent with the terms of the policy.

V. ORDER

The Commissioner upholds Humana Insurance Company's final adverse determination. Humana is not required to provide coverage for physical therapy beyond the maximum 20 treatments allowed per calendar year.

This is a final decision of an administrative agency. Under MCL 550.1915, any person aggrieved by this Order may seek judicial review no later than 60 days from the date of this Order in the circuit court for the county where the covered person resides or in the circuit court of Ingham County. A copy of the petition for judicial review should be sent to the Commissioner of Financial and Insurance Regulation, Health Plans Division, Post Office Box 30220, Lansing, MI 48909-7720.